

CONSENT FOR TREATMENT FOR MINOR/S & OTHERS

South FL Center for



Growth & Healing

Susanne R. Mealer, LCSW, CHT

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I _____
give my consent that **Susanne R Mealer, LCSW, CHT**, will be conducting psychotherapy and possible hypnotherapy with:

My relationship to the client (parent, uncle, etc.): _____

I was notified that the holder of the privilege is (parent, guardian, etc.)

I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form, which I have read and signed.

In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Susanne R Mealer, LCSW, CHT judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's well being.

Name (print)	Relationship	Signature	Date
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